FOR BHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046169

Facility Name: Lakewood Nursing & Rehab Center

Address: 1112 North Eastern Avenue (Number) Plainfield (City) 60544 (Zip Code)

County: Will

Telephone Number: (815) 436-3400 **Fax #** (815) 436-1357

HFS ID Number: 300124869001

Date of Initial License for Current Owners: 02/01/03

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code ____		[ ]	Corporation	[ ]	Other ____
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other ____		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 2/15/2005

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	103	37,145	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	103	37,145	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,292	13,712	5,075	34,079	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,292	13,712	5,075	34,079	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.75%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 103 and days of care provided 4,960

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	199,325	28,438	7,554	235,317		235,317	(6,889)	228,428			1
2	Food Purchase		166,455		166,455		166,455	5,900	172,355			2
3	Housekeeping	107,249	27,310		134,559		134,559	(2,522)	132,037			3
4	Laundry	48,870	24,599		73,469		73,469	(1,832)	71,637			4
5	Heat and Other Utilities			121,882	121,882		121,882	1,347	123,229			5
6	Maintenance	107,547		148,441	255,988		255,988	(3,271)	252,717			6
7	Other (specify):*							1,841	1,841			7
8	**TOTAL General Services**	462,991	246,802	277,877	987,670		987,670	(5,426)	982,244			8
	B. Health Care and Programs											
9	Medical Director			12,100	12,100		12,100		12,100			9
10	Nursing and Medical Records	1,844,728	132,747	11,889	1,989,364		1,989,364	(11,743)	1,977,621			10
10a	Therapy	156,355		930	157,285		157,285	322	157,607			10a
11	Activities	100,622	12,147	196	112,965		112,965		112,965			11
12	Social Services	104,411		660	105,071		105,071		105,071			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,288	1,288			15
16	**TOTAL Health Care and Programs**	2,206,116	144,894	25,775	2,376,785		2,376,785	(10,133)	2,366,652			16
	C. General Administration											
17	Administrative	89,586			89,586		89,586	20,199	109,785			17
18	Directors Fees											18
19	Professional Services			120,717	120,717		120,717	(76,763)	43,954			19
20	Dues, Fees, Subscriptions & Promotions			33,640	33,640		33,640	(10,787)	22,853			20
21	Clerical & General Office Expenses	67,693	20,158	188,792	276,643		276,643	(50,772)	225,871			21
22	Employee Benefits & Payroll Taxes			456,531	456,531		456,531	(2,569)	453,962			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,204	1,204		1,204	2,694	3,898			24
25	Other Admin. Staff Transportation			4,275	4,275		4,275		4,275			25
26	Insurance-Prop.Liab.Malpractice			92,307	92,307		92,307	1,123	93,430			26
27	Other (specify):*							16,539	16,539			27
28	**TOTAL General Administration**	157,279	20,158	897,466	1,074,903		1,074,903	(100,336)	974,567			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,826,386	411,854	1,201,118	4,439,358		4,439,358	(115,895)	4,323,463			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lakewood Nursing & Rehab Center #0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			16,154	16,154		16,154	176,354	192,508			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							217,402	217,402			32
33	Real Estate Taxes			49,131	49,131		49,131	1,108	50,239			33
34	Rent-Facility & Grounds			302,676	302,676		302,676	(297,430)	5,246			34
35	Rent-Equipment & Vehicles			9,562	9,562		9,562	957	10,519			35
36	Other (specify):*							39,370	39,370			36
37	TOTAL Ownership			377,523	377,523		377,523	137,761	515,284			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		289,696	427,480	717,176		717,176	(8,379)	708,797			39
40	Barber and Beauty Shops			4,108	4,108		4,108	(4,108)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,393	56,393		56,393	(676)	55,717			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		289,696	487,981	777,677		777,677	(13,163)	764,514			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,826,386	701,550	2,066,622	5,594,558		5,594,558	8,703	5,603,261			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50,199)	30		9
10	Interest and Other Investment Income	(49,166)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(663)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(938)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(12,683)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(62)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(127,146)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (301,857)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	310,561		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 310,561		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 8,703		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lakewood Nursing & Rehab Center

ID# 0046169

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (23)	21	1
2	Jury Duty Income	(40)	10	2
3	Patient Clothing	(72)	10	3
4	Barber & Beauty	(4,108)	40	4
5	Collection Expense	(211)	21	5
6	FY-2006 Seminar	(258)	24	6
7	Excess Bed Tax	(676)	42	7
8	Capitalized R&M	(9,512)	6	8
9	Non-allowable Legal	(197)	19	9
10	Building Co - Bank Charges	(167)	21	10
11	Building Co - Filing Fees	(250)	20	11
12	Building Co - State Replacement Tax	(100)	21	12
13	Building Co - Professional Fees	(13,400)	19	13
14	Non-Allowable Expense	(98,140)	21	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	**Total**	(127,146)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nursing & Rehab Center **#** 0046169 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(9)	214		2,442	(9,536)				(6,889)	1
2	Food Purchase	(663)							6,563				5,900	2
3	Housekeeping				(2,522)								(2,522)	3
4	Laundry				(1,832)								(1,832)	4
5	Heat and Other Utilities					1,347							1,347	5
6	Maintenance	(9,512)			(45)	3,293		2,970	23				(3,271)	6
7	Other (specify):*						717	777	347				1,841	7
8	**TOTAL General Services**	(10,175)			(4,408)	4,854	717	6,189	(2,603)				(5,426)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(112)			(11,631)								(11,743)	10
10a	Therapy							322					322	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						1,244	44					1,288	15
16	**TOTAL Health Care and Programs**	(112)			(11,631)		1,244	366					(10,133)	16
	C. General Administration													
17	Administrative					2,208		17,823	168				20,199	17
18	Directors Fees													18
19	Professional Services	(13,597)	13,400			(76,570)			4				(76,763)	19
20	Fees, Subscriptions & Promotions	(13,933)	250		(5)	2,896			5				(10,787)	20
21	Clerical & General Office Expenses	(159,641)	267			10,762		97,455	385				(50,772)	21
22	Employee Benefits & Payroll Taxes				(468)		(2,101)						(2,569)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(250)				2,811			133				2,694	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					1,004			119				1,123	26
27	Other (specify):*							16,539					16,539	27
28	**TOTAL General Administration**	(187,421)	13,917		(473)	(56,889)	(2,101)	131,817	814				(100,336)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(197,708)	13,917		(16,512)	(52,035)	(140)	138,372	(1,789)				(115,895)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lakewood Nursing & Rehab Center **#** 0046169 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(50,199)	210,882			14,034			64	1,573			176,354	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(49,166)	263,455			2,343			214	556			217,402	32
33	Real Estate Taxes					1,108							1,108	33
34	Rent-Facility & Grounds		(302,676)			5,246							(297,430)	34
35	Rent-Equipment & Vehicles					945			12				957	35
36	Other (specify):*		39,370										39,370	36
37	**TOTAL Ownership**	(99,365)	211,031			23,676			290	2,129			137,761	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(3,307)				(347)	(4,725)			(8,379)	39
40	Barber and Beauty Shops	(4,108)											(4,108)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(676)											(676)	42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(4,784)			(3,307)				(347)	(4,725)			(13,163)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(301,857)	224,948		(19,818)	(28,359)	(140)	138,372	(1,846)	(2,596)			8,703	45

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lakewood Plainfield Property LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 302,676	Lakewood Plainfield Property LLC		$	$ (302,676)	1
2	V	32	Interest	75,031	Lakewood Plainfield Property LLC		338,486	263,455	2
3	V	21	Bank Charges		Lakewood Plainfield Property LLC		167	167	3
4	V	20	Filing Fees		Lakewood Plainfield Property LLC		250	250	4
5	V	21	State Replacement Tax		Lakewood Plainfield Property LLC		100	100	5
6	V	19	Professional Fees		Lakewood Plainfield Property LLC		13,400	13,400	6
7	V	30	Depreciation		Lakewood Plainfield Property LLC		210,882	210,882	7
8	V	36	Amortization		Lakewood Plainfield Property LLC		39,370	39,370	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 377,707			$ 602,655	$ * 224,948	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 106,327	$ 106,327	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	106,327	CCS EMPLOYEE BENEFIT GROUP	100.00%		(106,327)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 106,327			$ 106,327	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		01	DIETARY	$ 87	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 79	$ (9)	15
16	V		02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V		03	HOUSEKEEPING	25,440	XCEL MEDICAL SUPPLY, LLC	100.00%	22,918	(2,522)	17
18	V		04	LAUNDRY	18,476	XCEL MEDICAL SUPPLY, LLC	100.00%	16,644	(1,832)	18
19	V		06	REPAIRS & MAINTENANCE	458	XCEL MEDICAL SUPPLY, LLC	100.00%	413	(45)	19
20	V		10	NURSING	117,319	XCEL MEDICAL SUPPLY, LLC	100.00%	105,687	(11,631)	20
21	V		11	ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V		20	DUES, FEES, SUBSCRIPTIONS & PROM	48	XCEL MEDICAL SUPPLY, LLC	100.00%	43	(5)	22
23	V		21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V		22	EMPLOYEE BENEFITS	4,722	XCEL MEDICAL SUPPLY, LLC	100.00%	4,254	(468)	24
25	V		39	ANCILLARY	33,351	XCEL MEDICAL SUPPLY, LLC	100.00%	30,045	(3,307)	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 199,901			$ 180,083	$ * (19,818)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 214	$ 214	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,347	1,347	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	3,293	3,293	17
18	V				Care Centers, Inc.	100.00%			18
19	V	17	Administration		Care Centers, Inc.	100.00%	2,208	2,208	19
20	V	19	Professional Fees	88,932	Care Centers, Inc.	100.00%	12,362	(76,570)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	2,896	2,896	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	10,762	10,762	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,811	2,811	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,004	1,004	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	14,034	14,034	25
26	V	32	Interest		Care Centers, Inc.	100.00%	2,343	2,343	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,108	1,108	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,246	5,246	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	945	945	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 88,932			$ 60,573	$ * (28,359)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		06	Maintenance Salary	$ 5,109	Care Centers, Inc.	100.00%	$ 5,109	$	15
16	V		07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	717	717	16
17	V		10	Nursing Salary	8,113	Care Centers, Inc.	100.00%	8,113		17
18	V		10a	Rehab Salary	906	Care Centers, Inc.	100.00%	906		18
19	V									19
20	V									20
21	V		15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,244	1,244	21
22	V		17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V		21	Office Salary		Care Centers, Inc.	100.00%			23
24	V		27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			24
25	V		22	Employee Benefits	2,101	Care Centers, Inc.	100.00%		(2,101)	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 16,229			$ 16,089	$ * (140)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 2,442	$ 2,442	15
16	V								16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,970	2,970	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	777	777	18
19	V								19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	322	322	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	44	44	21
22	V								22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	17,823	17,823	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	97,455	97,455	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	16,539	16,539	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 138,372	$ * 138,372	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 12,474	Care Centers, Inc. - Health Systems Division	100.00%	$ 654	$ (11,820)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	6,563	6,563	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	23	23	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	168	168	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	4	4	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	5	5	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	385	385	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	133	133	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	119	119	23
24	V	30	Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	64	64	24
25	V	32	Interest		Care Centers, Inc. - Health Systems Division	100.00%	214	214	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	12	12	26
27	V	39	Ancillary Enteral Supplies	732	Care Centers, Inc. - Health Systems Division	100.00%	385	(347)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,284	2,284	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	347	347	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,206			$ 11,360	$ * (1,846)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 1,573	$ 1,573	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	556	556	16
17	V	39	Vent Reimbursement	4,725	Vent Lease, LLC.	100.00%		(4,725)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,725			$ 2,129	$ * (2,596)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.72	1.56%	Alloc Salary	$ 1,739	17-7	1
2	Gale Rothner	Relative	Administrative	0.00%	See Attached	0.80	2.29%	Alloc Salary	1,775	17-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.25	2.27%	Alloc Salary	1,675	17-7	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.70	1.75%	Alloc Salary	867	22-7	4
5	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.64	1.83%	Alloc Salary	875	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,931		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 106,327	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 106,327	25

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 79	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						22,918	3
4	04	LAUNDRY	Direct Allocation						16,644	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						413	5
6	10	NURSING	Direct Allocation						105,687	6
7	11	ACTIVITIES	Direct Allocation							7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						43	8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						4,254	10
11	39	ANCILLARY	Direct Allocation						30,045	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 180,083	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	$ 9,406	$	34,079	$ 214	1
2	05	Utilities	Patient Days	1,497,287	32	59,188		34,079	1,347	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661		34,079	3,293	3
4										4
5	17	Administration	Patient Days	1,497,287	32	97,000		34,079	2,208	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148		34,079	12,362	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217		34,079	2,896	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845		34,079	10,762	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511		34,079	2,811	9
10	26	Insurance	Patient Days	1,497,287	32	44,126		34,079	1,004	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575		34,079	14,034	11
12	32	Interest	Patient Days	1,497,287	32	102,930		34,079	2,343	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662		34,079	1,108	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488		34,079	5,246	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		34,079	945	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,661,288	$		$ 60,573	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			301,710	301,710		5,109	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			46,639			717	2
3	10	Nursing Salary	Direct Cost			425,833	425,833		8,113	3
4	10a	Rehab Salary	Direct Cost			55,464	55,464		906	4
5										5
6										6
7	15	Emp. Ben. - Healthcare	Direct Cost			67,757			1,244	7
8	17	Administration Salary	Direct Cost			5,566	5,566			8
9	21	Office Salary	Direct Cost			419,879	419,879			9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			71,906				10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,394,755	$ 1,208,453		$ 16,089	25

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	34,079	2,442	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	34,079	2,970	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		34,079	777	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	34,079	322	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		34,079	44	7
8					32					8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	34,079	17,823	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	34,079	97,455	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		34,079	16,539	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,079,517	$ 5,316,753		$ 138,372	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452		46,000		13,206	654	1
2	02	Food	Income			160,931			6,563	2
3	06	Maintenance	Billable Income	928,452		1,614		13,206	23	3
4	17	Administration	Billable Income	928,452		11,797		13,206	168	4
5	19	Professional Fees	Billable Income	928,452		262		13,206	4	5
6	20	Dues & Subscriptions	Billable Income	928,452		342		13,206	5	6
7	21	Office & Clerical	Billable Income	928,452		27,087		13,206	385	7
8	24	Travel & Seminar	Billable Income	928,452		9,381		13,206	133	8
9	26	Insurance	Billable Income	928,452		8,379		13,206	119	9
10	30	Depreciaton	Billable Income	928,452		4,499		13,206	64	10
11	32	Interest	Billable Income	928,452		15,077		13,206	214	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843		13,206	12	12
13	39	Ancillary Enteral Supplies	Income			327,517			385	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	13,206	2,284	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382		13,206	347	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 11,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	$ 197,493	$	4,725	$ 1,573	1
2	32	Interest	Direct Billing	593,410	29	69,863		4,725	556	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,356	$		$ 2,129	25

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle Bank		X	Construction Loan			$	$ 748,501			$ 30,319	1
2	Business Partners		X	Mortgage				5,199,616			286,363	2
3	LaSalle Bank		X	Mortgage							12,190	3
4	Genesis		X					160,232			9,614	4
5	See Supplemental Schedule											5
	Working Capital											
6	Alloc from Vent Lease		X								556	6
7	Alloc from Care Centers		X								2,557	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 6,108,349			$ 341,599	9
	B. Non-Facility Related*											
10	Interest Income										(49,166)	10
11	Interest Income (Bldg Co)										(75,031)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (124,197)	14
15	TOTALS (line 9+line14)						$	$ 6,108,349			$ 217,402	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 46,099	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 47,538	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,439	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 50,239	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	51,450	8
	2001	52,662	9
	2002	45,196	10
	2003	43,903	11
	2004	46,430	12

2005 Accrual = 2004 Tax $46,430 x 1.05 = $48,800 (rounded)

Allocation from Care Centers $1108

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-10-312-003-0000	Long Term Care Property	$ 46,429.68	$ 46,429.68
2.	See Attached	Home Office Allocation	$ 113,458.70	$ 1,107.58
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 159,888.38	$ 47,537.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,925 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,121	2003	$ 237,379	1
2	2201 Main LLC allocation			8,005	2
3	TOTALS	273,121		$ 245,384	3

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,960,600	187,115		151,378	(35,737)	318,714	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		31,416	1,288		1,288		3,880	68
69	Financial Statement Depreciation			16,154			(16,154)		69
70	TOTAL (lines 4 thru 69)		$ 3,992,016	$ 204,557		$ 152,666	$ (51,891)	$ 322,594	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,992,016	$ 204,557		$ 152,666	$ (51,891)	$ 322,594	1
2	Security System	2003	2,803		20	400	400	1,001	2
3	Hot Water Heater	2003	4,719		20	393	393	983	3
4	Hot Water Repair	2003	2,632		20	219	219	512	4
5	Plumbing Repair	2003	1,650		20	83	83	186	5
6	Water Heater	2004	3,295		20	275	275	526	6
7	Hot Water System	2004	1,270		20	64	64	85	7
8	Water Heater	2004	908		20	45	45	61	8
9	Smoke Dampers	2004	1,082		20	54	54	72	9
10	Compressor	2004	5,987		20	299	299	399	10
11	Generator	2004	1,181		20	169	169	225	11
12	Wall Heater	2004	818		20	68	68	80	12
13	Engineering Fees	2004	2,350		20	118	118	137	13
14	Nurse Call System - Call Cords	2004	607		20	30	30	61	14
15	Alarm - Transmitter	2004	516		20	26	26	45	15
16	Alarm - Controller / Receiver	2004	1,215		20	61	61	106	16
17	Overbed Lights	2004	656		20	33	33	55	17
18	Alarm Repairs	2004	557		20	28	28	46	18
19	Cubicle Curtains	2004	1,738		20	87	87	145	19
20	Roof Work	2004	1,665		20	83	83	132	20
21	Alarms	2004	763		20	38	38	60	21
22	New Locks	2004	729		20	36	36	46	22
23	Wall Unit - Circuit Board	2004	838		20	42	42	49	23
24	Electrical Relocation	2004	15,497		20	775	775	969	24
25	Dining Room Renovations	2005	3,000		20	138	138	138	25
26	Spinkler Heads	2005	6,000		20	214	214	214	26
27	Roof Repair	2005	1,750		20	58	58	58	27
28	Blinds	2005	1,885		20	16	16	16	28
29	Sprinkler	2005	1,957		20	8	8	8	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,060,084	$ 204,557		$ 156,526	$ (48,031)	$ 329,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	103		2003		$ 1,915,178	$ 49,105	39	$ 49,107	$ 2	$ 147,321	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Lakewood Plainfield Property (See Attached)			2003	691,220	113,377	20	34,561	(78,816)	103,683	9
10	Construction Project			2005	1,354,202	24,633	20	67,710	43,077	67,710	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,960,600	$ 187,115		$ 151,378	$ (35,737)	$ 318,714	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC allocation		2002	2002	$ 11,031	$ 283	39	$ 283	$	$ 931	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from 2201 Main LLC			2002	9,112	456	20	456		1,595	9
10	Allocation from 2201 Main LLC			2003	10,739	537	20	537		1,342	10
11	Allocation from 2201 Main LLC			2005	534	12	20	12		12	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 31,416	$ 1,288		$ 1,288	$	$ 3,880	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 222,608	$ 36,801	$ 30,805	$ (5,996)	10	$ 89,658	71
72	Current Year Purchases	56,355	223	4,051	3,828	10	4,051	72
73	Fully Depreciated Assets	7,225				10	7,225	73
74								74
75	TOTALS	$ 286,188	$ 37,024	$ 34,856	$ (2,168)		$ 100,934	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers allocation		$ 15,369	$ 1,126	$ 1,126	$	5	$ 11,639	76
77										77
78										78
79										79
80	TOTALS			$ 15,369	$ 1,126	$ 1,126	$		$ 11,639	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,607,025	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 242,707	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 192,508	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (50,199)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 441,582	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers				5,246			5
6								6
7	TOTAL				$ 5,246 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 10,519 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 66,466	$		$ 66,466	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			39,405			39,405	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			317,741			317,741	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				195,630		195,630	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					3,868	94,066		97,934	13
14	TOTAL			$		$ 427,480	$ 289,696		$ 717,176	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center **#** 0046169 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 57,568	$ 82,571	1
2	Cash-Patient Deposits	26,904	26,904	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	863,557	872,255	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	223,290	223,290	6
7	Other Prepaid Expenses	21,368	21,368	7
8	Accounts Receivable (owners or related parties)	1,186,404	1,211,799	8
9	Other(specify): See Attached Schedule	13,167	13,167	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,392,258	$ 2,451,354	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		4,084,382	14
15	Leasehold Improvements, at Historical Cost	50,678	50,678	15
16	Equipment, at Historical Cost	102,537	102,537	16
17	Accumulated Depreciation (book methods)	(33,668)	(692,403)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		127,958	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(58,603)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		1,950,997	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 119,547	$ 5,802,925	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,511,805	$ 8,254,279	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 561,490	$ 561,489	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,656	18,656	28
29	Short-Term Notes Payable		160,232	29
30	Accrued Salaries Payable	192,778	192,778	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,125	10,125	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,800	48,800	32
33	Accrued Interest Payable		34,181	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	309,307	309,307	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,141,156	$ 1,335,568	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,948,117	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,948,117	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,141,156	$ 7,283,685	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,370,649	$ 970,594	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,511,805	$ 8,254,279	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,323,468	1
2	Restatements (describe):		2
3	See Attached	(57,659)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,265,809	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	333,538	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(228,698)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 104,840	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,370,649	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,612,534	1
2	Discounts and Allowances for all Levels	(1,501,316)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,111,218	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,438,253	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,438,253	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,259	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	187,865	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,784	19
20	Radiology and X-Ray	7,230	20
21	Other Medical Services	76,040	21
22	Laundry	5,218	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 329,396	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,166	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,166	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	63	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 63	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,928,096	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	987,670	31
32	Health Care	2,376,785	32
33	General Administration	1,074,903	33
	B. Capital Expense		
34	Ownership	377,523	34
	C. Ancillary Expense		
35	Special Cost Centers	721,284	35
36	Provider Participation Fee	56,393	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,594,558	40
41	**Income before Income Taxes (line 30 minus line 40)****	333,538	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 333,538	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,839	2,091	$ 69,415	$ 33.20	1
2	Assistant Director of Nursing	1,880	2,101	57,230	27.24	2
3	Registered Nurses	15,421	17,049	450,000	26.39	3
4	Licensed Practical Nurses	18,868	20,850	471,087	22.59	4
5	CNAs & Orderlies	60,111	67,105	759,502	11.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,570	9,435	156,355	16.57	8
9	Activity Director	1,944	2,177	45,175	20.75	9
10	Activity Assistants	6,520	6,985	55,447	7.94	10
11	Social Service Workers	5,465	5,636	104,411	18.53	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,137	37,874	17.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,345	5,864	71,176	12.14	15
16	Dishwashers	10,351	11,356	90,275	7.95	16
17	Maintenance Workers	5,657	6,183	107,547	17.39	17
18	Housekeepers	12,118	13,368	107,249	8.02	18
19	Laundry	5,188	5,701	48,870	8.57	19
20	Administrator	2,074	2,238	89,586	40.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,627	6,187	67,693	10.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,911	1,974	37,494	18.99	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	170,737	188,437	$ 2,826,386 *	$ 15.00	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	245	$ 7,554	01-03	35
36	Medical Director	monthly	12,100	09-03	36
37	Medical Records Consultant	monthly	1,448	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,302	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	196	11-03	44
45	Social Service Consultant	12	660	12-03	45
46	Other(specify) Therapy Consult		24	10A-03	46
47	URC Consultant		26	10-03	47
48	CCI - see attached		9,019	various	48
49	TOTAL (lines 35 - 48)	261	$ 33,329		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Brune	Administrator	0	$ 10,113
Scott McBride	Administrator	0	73,161
Richard Edelmann	Administrator	0	6,312
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,586

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers Inc.	Home Office Expense	$ 66,960
Care Centers Inc.	Bookkeeping	18,972
Frost, Ruttenberg & Rothblatt	Accounting	10,800
Personnel Planners	Unemployment Consult	285
TBT Enterprises	Unemployment Consult	649
Talx Corporation	Unemployment Consult	218
ADP Inc.	Payroll Processing	7,443
Ehealth Data Solutions	MDS Software	1,769
Various - See Attached	Legal	4,293
Care Centers Inc.	Other Professional Fees	3,000
Legat Architects	Architects	3,696
See Supplemetal Schedule		2,632
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 120,717

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,795
Unemployment Compensation Insurance	69,549
FICA Taxes	210,470
Employee Health Insurance	65,938
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	6,362
Other Employee Welfare	3,541
Holiday Expense	1,307
TOTAL (agree to Schedule V, line 22, col.8)	$ 453,962

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,161
Advertising: Employee Recruitment	12,650
Health Care Worker Background Check	3,026
(Indicate # of checks performed 135)	
License & Fees	915
Advertising & Promotion	12,683
Dues & Subscriptions	2,205
Allocation from Care Centers	2,901
Allocation from XCEL Medical Supply	(5)
Less: Public Relations Expense	( )
Non-allowable advertising	(12,683)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,853

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	954
Allocation from Care Centers	2,944
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,898

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center # 0046169 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,928** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **55,717**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.